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ABSTRACT

Discussed are current and proposed Georgia interagency programs for delivering mental health services to behaviorally disordered (emotionally disturbed-socially maladjusted) children through age 21 years by 1976. Considered in a brief overview of state programs are services (such as the Georgia Psychoeducational Center Network) for elementary and secondary school students, public and private residential facilities, and university training programs for special education teachers and mental health professionals. Among public school delivery models cited in section 2 are the Thomasville Learning and Resource Center, which stresses a learning disabilities approach, and the Cooperative Educational Services Agencies (CESAs), which operate shared services in rural areas. Special public school projects described in section 3 include the Pioneer CESA Special Education Leadership Services Division (one of 16 CESA units providing support to local school systems) and the ALPINE Center Project, which provides services to severely disturbed children. Explained in section 3 are the Georgia Psychoeducational Network and its utilization of a developmental therapy system. Sections 4 and 5 feature community youth services for juvenile offenders and an outdoor therapeutic program. An overview of training programs for teachers of behaviorally disordered children is given in the final section. (LH)

TOTAL MENTAL HEALTH SERVICES IN GEORGIA

Contents

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DELIVERY SYSTEM FOR A TOTAL STATE MENTAL HEALTH PROGRAM FOR CHILDREN AND YOUTH IN GEORGIA

In planning services for all emotionally disturbed/socially maladjusted children and youth in Georgia, all inter-agency resources are considered tantamount for a total mental health effort. At the state level there is strong support from the Governor and from departments of state as well as legislative backing for such cooperation.

The public schools are mandated by Georgia H.B. 453 to provide comprehensive programs for all exceptional school-age children, including those classified as emotionally disturbed/behaviorally disordered by 1976. The Department of Human Resources (Division of Family and Children's Services and the Division of Public Health), the Department of Natural Resources and state universities are all cooperating in a collaborative effort to help bring this mandate to reality.

Over the past few years the State Special Education Program for children with behavior disorders has grown from 67 public school programs in 1962-63 to 312 programs in the 1973-74 school year. There is need, however, for continued expansion of mental health services both in the schools and including ancillary/other agency resources.

Statistics Reflecting Growth 1962-74

Year	Units	Children Served
1962-63	9	67
1963-64	12	112
1964-65	25	218
1965-66	31	734
1966-67	39	1,451
1967-68	39	1,481
1968-69	31	788
1969-70	33	739
1970-71	47	1,349
1971-72	67	2,670
1972-73	171	5,549
1973-74	312	10,000

School Programs

Initially most programs for emotionally disturbed children in the public schools were set up on a self-contained model with the elementary age group of primary concern. In the past few years, programs have grown more to the resource model with approximately 75% of all B.D. classes using this structure. Both public school class composition and Psychoeducational Center make-up may be considered inclusive in this figure. As programs grow, however, and attention is given to the 14-18 group, other delivery models for service must also be considered.

Services for Elementary Children

Concentration of services to children in Georgia has been on the elementary level. At present, existing services for the age group 0-14 consists of (1) 205 classes in the public schools, (2) 60 classes in centers for severely disturbed children, and (3) 30 classes located in institutions such as Central State, the other Regional Hospitals and several other carefully designated specialty units. These services for 0-14 cover children with all degrees of disturbance from mild to severe. Mild and moderately disturbed children generally are given public school placement, while severely disturbed children receive partial day service in a center program.

As a delivery system for services to the severely disturbed child, 0-14 years of age, the Georgia Psychoeducational Center Network has been established. Full implementation of the network is to be accomplished over a three year period. During this time 24 centers and their satellites will be established. Centers are located in strategic geographic areas of the state.

In the Metropolitan Atlanta Area, the South DeKalb Children's Center, although not a part of the network, is also engaged in services for severely disturbed children. Operating also on state funding, the center has been in existence for the past four years. The Clayton County Health Center, Title VI-A funded, is working cooperatively with the Clayton County School System in offering services for severely disturbed children. The Southside Comprehensive Mental Health Center, in conjunction with the Atlanta City School System operates another program for pre-school severely disturbed at the Jesse Mae Jones School.

The need for services to youth 14-18 is just beginning to be met. Actual secondary resource units in the high schools are limited to approximately thirty classes statewide. Ancillary resources consist of 825 high school counselors who provide counseling and guidance services to high school students. The population whose major problems are truancy and expulsion are worked with by 350 visiting teachers. Outside the secondary schools, community mental health centers and various state residential facilities serve youth whose degrees of disturbance may be severe.

Community Support Services and Residential Facilities
For
Emotionally Disturbed Youth and Social Offenders 14-18

	Approximate Number FY 1972	Average Duration of Stay or Treatment
Community Mental Health Centers	No Information Available	———
Drug Treatment Centers	128	20 to 30 Days
Regional Hospitals (inpatient)	130	———
Georgia Mental Health Institute (inpatient services)	144	———
Central State Hospital (inpatient)	422	———
Prisons	1,063	Usually long term (major crimes)
Urban Dentention Homes (includes abandoned children)	14,541	Short Term
Youth Development Centers	1,465	Nine Months
Crittendon Homes	1,500	Approx. 2

Particularly at this secondary level, there is need for the combined efforts of all mental health agencies to ensure a continuum of treatment services. Because of the numbers of adolescents whose problem behaviors result in delinquent acts, other agency intervention becomes necessary. Correctional agencies are now providing alternatives to institutionalization through the establishment of Group Homes, Com-

munity Treatment Centers, and Day Care Centers under the Georgia Department of Human Resources. Education agencies are cooperating in these efforts with the placement of special education teacher units in these facilities. With educational remediation and/or vocational skills training these youth are assisted in either re-entry for further school placement or in securing jobs in the community.

Programs of this nature have been highly successful in several areas of the state. The community treatment center in Thomasville, for instance, has a close working agreement with the school system. The Thomasville City School System acts as fiscal agent for the teacher unit allocation and supplies books and other materials for the special education teacher housed at the center. Youth terminated from the Center receive close follow-up from both center staff and school principals and others concerned with the placement of students into regular school classes. Continued efforts of this nature are being encouraged in other areas of the state, and our goal is the establishment of special classes in these centers statewide.

Many school systems also have mutually beneficial agreements with Comprehensive Mental Health Centers for psychotherapeutic services to this adolescent population. To meet the need for special services to seriously acting out youth in the Valdosta City School System, the Comprehensive Mental Health Center in that area actually houses a special class for these students with a teacher provided by the school system. With the supportive services of center staff, many of these youth are gradually phased back into a regular school program.

Still another innovative inter-agency collaboration is the Therapeutic Camping Program for socially maladjusted children and youth, age 8-18. A combined project of the Departments of Human Resources and Natural Resources and funded through an LEA grant, this program emphasizes an outdoor camping approach to therapy. Although presently most referrals will be made by correctional agencies, the program services will be expanded to include a preventive component for other children and youth exhibiting emotionally problems. The camping facilities are located at Unicoi State Park in the north Georgia mountains. The camp is residential and includes both long and short term camping experiences. Plans are being made to establish a structured educational unit in

the camping situation. It is felt that the program can then supply a continuum of services which will enable children to return to the community with the necessary skills for regular school and vocational placement

Private Residential Programs

In considering the varied and often multiple needs of emotionally disturbed children and youth, we can not overlook the fact that good private residential care is required for some children. Several facilities of this kind are located in different areas of the state.

College and University Training Programs

Currently, Georgia's colleges and universities are working closely with other mental health programs and agencies in the training of special education teachers as well as other mental health professionals in psychology and social work. Armstrong State College, (Savannah); Georgia Southern College, (Statesboro); Georgia State University, (Atlanta); Valdosta State College, (Valdosta); University of Georgia, (Athens); and, West Georgia College, (Carrollton), all offer coursework in the field of Behavior Disorders. Some differentiation is being made in the training of teachers on the elementary and secondary levels. The following table indicates the numbers of fully certified teachers needed to supply our mandate needs by 1976.

Certification of B.D. Teachers

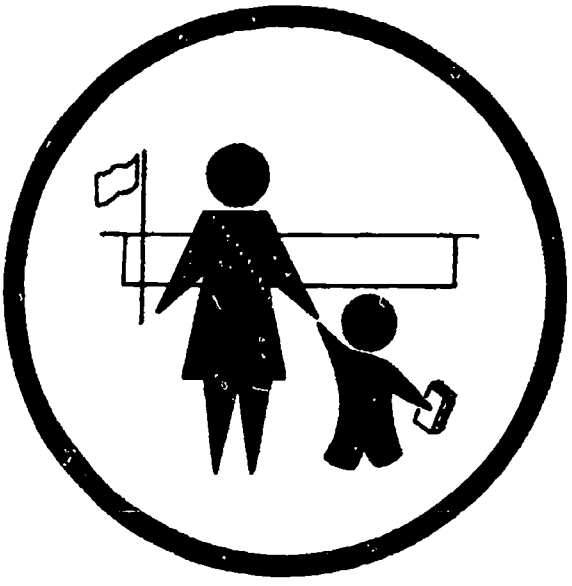
	72-73	73-74	74-75	75-76
B.D. Teachers fully certified	45 (26%)	166 (46%)	410 (70%)	770 (95%)
B.D. Teachers with 15 hours in field	39 (23%)	86 (24%)	59 (10%)	41 (5%)
B.D. Teachers with 20 hours in field	34 (20%)	36 (10%)	88 (15%)	0
B.D. Teachers with 30 hours in field	53 (31%)	72 (20%)	29 (5%)	0
TOTAL	171	360	586	811

We are highly dependent, therefore, upon the continued growth and expansion of training programs to supply this demand. Although we have been successful in the recruiting of many highly qualified personnel from out-of-state, we must rely heavily on the training and retraining from our own teacher resources.

Total Collaboration Benefits

Efforts for delivery of services to all behaviorally disordered children in Georgia are being made and documented successes can be observed. Hopefully, our 1976 mandate will be fulfilled, and a complete mental health service delivery for children and youth will be effected. Education can provide specially trained teachers, counselors and school psychologists in its part of the effort. The cooperation of mental health agencies, community service organizations and correctional agencies is essential if complete mental health programs are to be offered the 0-21 age group in Georgia.

Dorothy Whitney, Consultant
Behavior Disorders
Georgia Department of Education



PUBLIC SCHOOL PROGRAMS

PUBLIC SCHOOL PROGRAMS IN BEHAVIOR DISORDERS

Dorothy Whitney, Consultant, Behavior Disorders
Department of Education, Atlanta, Georgia

During the past two years one of the top priorities of the Georgia Department of Education has been the development of a strong Behavior Disorders component in the Special Education Program. Using a conservative U.S. Office of Education incidence figure of 2%, we estimate that approximately 23,528 of our school age population are emotionally disturbed/behaviorally disordered and need services in the schools.

Our effort has been concerned with the establishment of public school classes for behaviorally disordered children and youth on both the elementary and secondary levels whose problem behaviors range from mild to moderate. The previously mentioned Georgia Psychoeducational Network, with centers strategically located through out the state, provides partial day care for seriously disturbed youngsters, 0-14.

At the state level an attempt has been made to suggest adequate models for the delivery of services to these behaviorally disordered children in the public schools. Obviously, all of the needs of these students can not be met in the schools alone. Thus we have solicited interagency intervention to extend a continuum of services. These collaborative ventures have been discussed in the overview of this publication.

We are, nevertheless, in the State Special Education Program, faced with the task of assisting in the establishment of new programs for the behaviorally disordered population in the public schools. We are in the position to consult with school systems in these matters, and we recommend that program composition in terms of managerial and administrative aspects be based upon:

1. Geography of the particular areas.
2. Demographic factors.
3. Levels of existing services (public and private).

4. Interagency cooperative service agreements.
5. Availability of facilities and staff.
6. Number and location of training institutions offering Behavior Disorders programs.
7. Alternative ways of providing teacher preparation.

Presently, we are suggesting, with the above factors in mind, that elementary public school classes be operated on the three basic traditional operational models of self-contained, resource and itinerant. The itinerant service model has been employed extensively in rural areas in the state, where the shortage of trained teachers has made it a viable one for service delivery. School systems are planning the addition of more extended public school classes for the behaviorally disordered as more trained teachers become available.

A new delivery model emerging in some of the systems is one based upon interrelated class services for all mild and moderately mentally handicapped elementary children. A pilot project funded through ESEA, Title III, P.L. 90-247, the Learning and Resource Center (LARC) in the Thomasville area, has been highly successful in documenting student social and academic gains. Although the curriculum stresses a learning disabilities approach, behaviorally disordered children have profited from enrollment in these centers. Mrs. Miriam Tannhauser, well known in the field of learning disabilities, has acted as chief consultant to the project and has provided on-going teacher and paraprofessional staff training.

Other areas of the state are beginning to implement similar type programs, and Georgia State University is now offering an Interrelated Specialist Master's program to help meet the demand of teachers prepared for these classroom resource services.

On the secondary level in the public schools, we are proposing that a possible method for serving behaviorally disordered youth might be a team approach to the problem. This model will serve a dual purpose of: (1) bringing extended services of two related disciplines(Behavior Disorders and counseling) to the student and (2) of serving a larger number of students than a single teacher might see. A three member team-teacher, school counselor and a paraprofessional will provide resource support services to youth exhibiting problem behaviors. We propose that such teams be based at the

larger high schools in the state or work on an itinerant basis in more sparsely populated areas

Already, several school systems in the state are implementing Behavior Disorders programs serving all chronological levels and degrees of disturbance in their behaviorally disordered school populations. DeKalb County, located in the metropolitan Atlanta area, is now operating 61 classes in the area of Behavior Disorders. A center program serves seriously disturbed students and public school classes range from those set up on the resource basis to self-contained classrooms operating on Hewett's engineered classroom model. Pilot projects at the secondary level are housed at two of the larger high schools. In addition, DeKalb County has instituted a strong peer program for tutorial help to emotionally disturbed elementary students.

Douglas County, another metropolitan area system, is also implementing a program offering all levels of service in the school year 1973-74. During the summer of 1973, teachers, counselors, school psychologists, and state consultants cooperated in producing a draft of a Program Guide to Behavior Disorders for the county. This guide, which will be completed next summer, will incorporate all aspects of administrative, curriculum and referral procedures for establishing a total behavior disorders program. Dissemination will be to school systems statewide. Hopefully, it will be useful in the initiation of new programs.

Other metropolitan systems such as Chatham County (Savannah) and Bibb County (Macon) are well underway in offering public school and Psychoeducational Center Programs for their students.

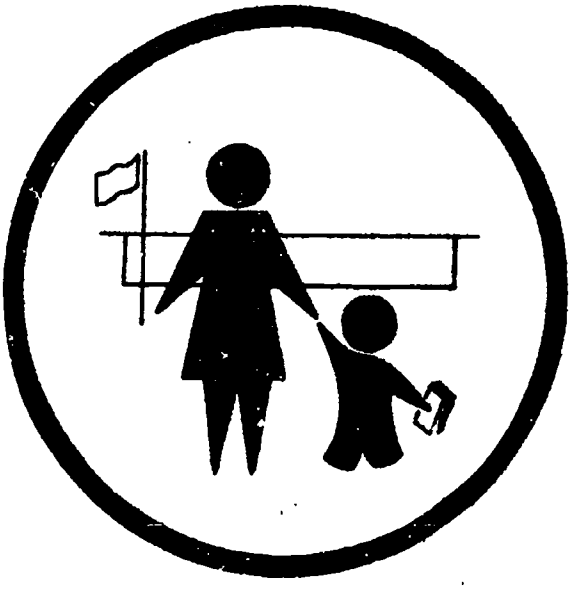
Even more sparsely populated areas of the state, where total program implementation is not feasible presently, are progressing toward this goal. Major facilitating agents for delivering these services to rural areas have been the sixteen Cooperative Educational Services Agencies (CESAs) operating on a shared services concept. Consultants and instructional personnel based at these units can offer some degree of service to the most remote areas of the state.

In the effort to alleviate the teacher shortage in Behavior Disorders, the Special Education Program, Georgia Department of Education, has for the past two years subscribed to a sum-

mer institute teacher training plan. Through monies available (P.L. 91-230), three summer institutes were held in 1972, and five were operated during the summer of 1973. These institutes were located in areas of the state where the teacher shortage appeared most acute. Coursework was given by university staff and was designed to provide teachers already possessing an undergraduate teaching certificate with initial master's level competencies in Behavior Disorders. Approximately 150 beginning teachers were prepared in this manner.

To give continuing support to these teachers as well as other professionals already in the field, the State Special Education Program has worked cooperatively with CESAs and with individual systems to present a series of workshops directed toward specific problem areas in Behavior Disorders. These workshops have dealt with topics such as drug abuse, parent-child relationships, therapeutic camping procedures and adolescent problem areas. The Georgia Learning Resources System has offered materials and videotaping capabilities in conjunction with these efforts.

Thus the provision of all resources to assist in good mental health for students is, we feel, part of the educative task of Georgia's school systems. With this philosophical orientation in mind as well as our legal mandate through H.B. 453, we hope that development of public school programs can result in complete implementation of Behavior Disorders programs in our schools by 1976.



PUBLIC SCHOOL PROGRAMS

Special Projects

DELIVERY OF SERVICES TO MENTAL HEALTH IMPAIRED CHILDREN AND YOUTH WITHIN THE ORGANIZATIONAL STRUCTURE OF A COOPERATIVE EDUCATIONAL SERVICE AGENCY

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Overview

The ability of many public school systems in Georgia to respond to the needs of mental health impaired children has been de-limited by several factors. Prior to the development of Cooperative Educational Service Agencies (CESA) small school systems lacked the human and financial resources required to deliver comprehensive special education services. The CESA concept is an administrative organizational unit which has great potential to enhance the educational and instructional opportunities of all boys and girls enrolled in local school systems, including those in need of special education.

The Pioneer Cooperative Educational Service Agency, one of sixteen CESA units in Georgia, is comprised of fourteen member school systems located in the extreme northeast thirteen counties in the State. The size of the school systems in this region and inadequate financing result in limited educational staffs and instructional program opportunities. The CESA unit provides educational leadership and support services in curriculum and instruction, student personnel services, and school business services. Prior to the existence of Pioneer CESA no school related services were provided for behavioral disordered, or emotionally disturbed children or youth in any of the school systems served.

Special Education Leadership Services

Personnel with the Special Education Leadership Services Division of the Pioneer CESA serve in an array of leadership roles to District school systems in planning, implementing, and operating special education programs and services. Services available are designed to support and supplement the efforts of local school systems in responding to the many

and varied needs of handicapped children. In limited instances direct service programs are actually operated at the CESA level. Such direct service programs and services are those which member school systems cannot offer because of previously described factors and characteristics.

Twenty-four persons are employed in the Special Education Leadership Services Division in various programs and services. Instructional specialists, consultants and support technicians in the areas of school psychology, mental retardation, behavior disorders, speech and hearing, and special education administration are available through the CESA Center to local school systems.

The Division of Special Education Leadership Services also operates two direct service projects for mental health impaired children and adolescents. These projects are discussed in a subsequent section of this narrative. Staff development, research and development, proposal development, comprehensive studies, and public relations and promotional services as they relate to special education are also provided.

Special Projects and Services for Mental Health Impaired Children and Adolescents

Few efforts have been attempted through education to meet the mental health needs of school aged children and adolescents. Historically, American public education has not perceived itself as a mental health agent in the lives of disturbed youth. The typical school response to behavior disordered children and adolescents has been some form of school separation. School authorities either commission the expulsion or, through lack of positive intervention, force the behavior disordered student to voluntarily withdraw from school. In either situation the burden of responsibility has been on the child, the person least able to assume responsibility.

Like their counterparts across the country, schools in Northeast Georgia have been slow to respond to the mental health needs of their students. However, school systems in this geographic area have been handicapped by many of the factors and conditions previously described. Northeast Georgia is a picturesque low mountainous area with sparsely populated communities many of which are isolated, and others situated so as to preclude effective and efficient inter-regional commuting.

The low prevalence level of mental health impairments and the regional geographic and sociological factors combine as barriers which have made programming for these children difficult, or in most cases impossible. Prior to the 1973-74 school year there were no public school services for behavioral disordered or emotionally disturbed children and youth. The Division of Special Education Leadership Services, Pioneer CESA responded to this program void through the development of operation of several projects and activities.

School Centered Services

Concentrated assistance has been given to local school systems with respect to recognizing the need for providing services for children with mild behavioral problems. Behavioral disordered programs have been planned, appropriately trained teachers have been recruited, children have been identified and programs have been implemented. It is planned that every school system will soon have a direct service program for children of all ages with mild behavioral or mental health problems. School oriented services are perceived to be the basic component of a comprehensive mental health outreach program for children and youth.

ALPINE Center Project--

The ALPINE Center (Alternative Learning Program – Innovative Needs Evaluation) is a member of the S.E.D. Network in Georgia. As such it provides essentially the same services as other Network Centers. Administratively the ALPINE Center operates as a CESA Project. One major advantage of this organizational structure is that the Project is accepted as a CESA activity and not as a non-school agency project.

The ALPINE Center provides an array of service to children and their parents, as well as support services for school system personnel. Educational therapy, social work, and psychological and psychiatric evaluations are but a few of the services provided.

The ALPINE Center is a viable component in a comprehensive mental health program of disturbed children. Its prime objective is to provide services to children so severely disturbed they would otherwise be institutionalized.

Secondary B.D. Project--

In an attempt to serve the needs of secondary school students with mental health problems the following delivery model has been designed:

A team approach has been organized at the CESA level. This strategy achieves three objectives: (1) It brings extended services of two related disciplines (B.D. and social work) to the student; (2) It serves a larger number of students than a single teacher might see; and (3) It allows small isolated high schools to participate in programs which their size and location might otherwise prohibit. This model provides a mobile team to work with students with behavior problems in their school and home environment. Each team member fulfills a differentiated role in relation to the team function.

The Secondary B.D. Project represents a service delivery prototype. A review of the professional literature has failed to document the existence of other programs or projects which duplicated the objectives and outreach services of the Secondary B.D. Project. This Project is viewed as another of the vital components of a comprehensive mental health delivery program. This comprehensive service delivery scheme provides for the public schools to make available in-school services for children and adolescents with mild to moderate mental health problems, and also for a program to respond to the needs of youngsters with severe behavioral or emotional disorders.

Inter-relationships With Other Agencies

The ALPINE Center Project and the Secondary B.D. Project have been planned and implemented to include a functional inter-relationship with several agencies involved with mental health services. The agencies include:

1. The Georgia State Department of Human Resources
2. The Georgia State Department of Education
3. The Georgia State Department of Natural Resources
4. Local Mental Health Agencies

The cooperative involvement includes the attendant divisions and sub-groups of each of the above mentioned State Departments. In such a manner the project described and other [illegible] systems and Pioneer CESA activities will merge into a "Total State Delivery System for Mental Health Impaired Children and Youth".

GEORGIA PSYCHOEDUCATIONAL CENTER NETWORK

THE GEORGIA PSYCHOEDUCATIONAL NETWORK

Peggy Pettit, Director, Burwell Center
Carrollton, Georgia

The Georgia Psychoeducational Network is designed as a comprehensive community based system combining psychological and educational services to serve severely emotionally and behaviorally disordered children aged 0 to 14 and their families. It is a coordinated program between Mental Health, Special Education, the University of Georgia, local school systems and mental health centers; and it is funded by the State of Georgia, through the Georgia Department of Education.

The design for the Georgia Psychoeducational Center Network grew from the experiences of parents, teachers, clinicians, legislators, and a caring community seeking ways to help seriously disturbed children. Distraught, concerned, and frustrated with the paucity of services and the overwhelming need for help, these concerned people joined in a cooperative effort to establish a system which could offer significant services to any seriously emotionally or behaviorally disturbed child, anywhere in Georgia.

Because services for severely emotionally disturbed children were seen as the joint responsibility of education and mental health programs, the Department of Education and the Department of Human Resources planned and implemented a joint service delivery system for these children and their families. This system, the Georgia Psychoeducational Center Network, is one part of an array of special education and mental health services needed for children. The program is developed through both local school systems and community mental health agencies in cooperative planning and operation.

Beginning in 1970, a two year demonstration project at the Rutland Center in Athens, Georgia, became the prototype for the statewide network, demonstrating and evaluating several basic convictions about ways to most effectively reduce severe emotional and behavioral problems of young children. These convictions are:

1. Keep these children out of a residential institution by offering comprehensive services in their communities.
2. Keep their families actively involved in supporting ways.
3. Keep them in regular school, with teachers actively involved, while special help is given.
4. Bring child specialists from Mental Health and Special Education together in a collective effort on behalf of these children.

The Network started operation July 1, 1972, with Centers in Athens, Savannah, Brunswick, Valdosta, Thomasville, Carrollton and Waycross, serving 1200 children and their families during the fiscal year 1972-1973. Eight more community based centers, located in Americus, Dalton, Dublin, Gainesville, Macon, Milledgeville, Rome, and Waynesboro, began operating in July, 1973. This Network of fifteen centers, covering 113 counties, will serve more than 3,000 severely emotionally or behaviorally disturbed children and their families by the end of July, 1974.

There are still an estimated 2,991 severely disturbed children and their families in counties not presently being served. Eight additional centers are now projected to fulfill the networks goal by 1975, making a Psychoeducational Center Program available within a 30 minute drive for any child in Georgia.

What makes the Georgia Psychoeducational Center Network unique? It is comprehensive. Each child referred to a psychoeducational center may receive a full range of services, including thorough diagnosis, treatment, periodic evaluation, and follow-up.

It is a cooperative effort by the Mental Health and teaching profession, capitalizing on the benefits of a team utilizing psychologists, psychiatrists, educators, social workers, parents, and others.

It is community based and offers help to a group of children who are usually excluded from schools and often isolated from friends and family. Instead of being in an institution, children remain with their families and receive the services they need in a psychoeducational center close to home. Usually they remain enrolled in a regular school program part-time while receiving help at a psychoeducational center.

It offers assistance to parents and regular school teachers who may influence and help disturbed children, but who frequently need guidance in order to be effective.

It reaches the geographically distant counties of the state by a series of outpost or field centers, bringing psychoeducational services within 30 minutes of any child in Georgia.

It is working, and its successes are being documented through a network-wide evaluation system.

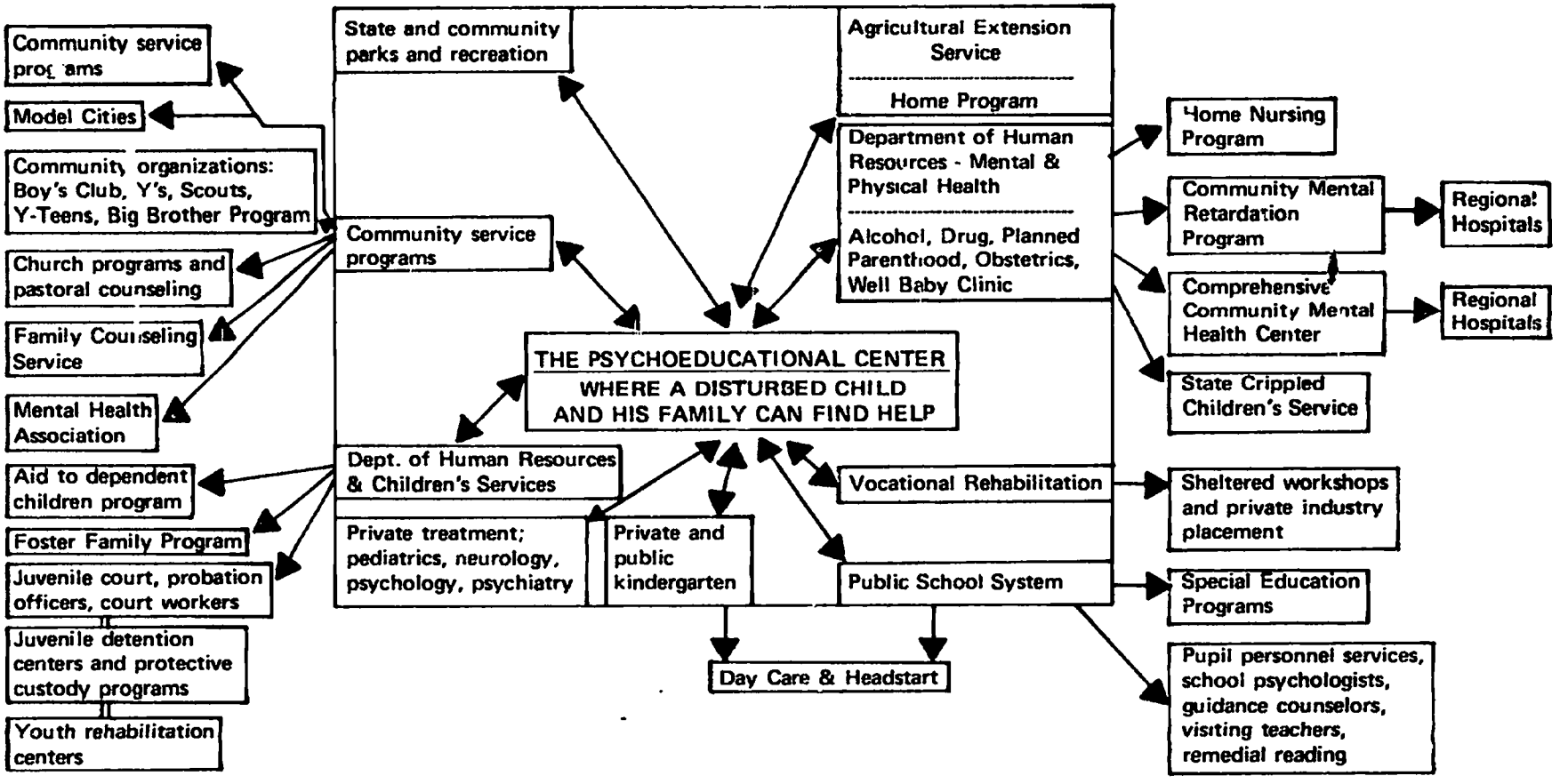
Because the network delivers services that unify educational, developmental and psychological services, inte.disciplinary and inter-agency cooperation at the state and local level are essential. Figure 1 portrays the psychoeducational center as a source for coordinated services for disturbed children. Such cooperation makes the network unique and insures that it is effective and able to deal with a child and his total environment. No center in the network can operate effectively in isolation from any of the professional resources of its local area.

The staff of each center includes professionals from several fields —— psychiatrists, psychologists, social workers and special educators. In addition to delivering its particular service program, this staff serves as supplementary to and supportive of local educational, day care, childhood development and mental health programs.

The network is in itself a specialized service for exceptional children. It constitutes one alternative to the institutionalization of children with serious emotional disturbances who have difficulties remaining in a normal school environment or who manifest severe emotional problems at the pre-school or school age. The specific benefits of the Georgia Psychoeducational Network are: (a) combining the resources of mental health and education for more effective utilization of resources and professional manpower and the education and treatment of severely emotionally and behaviorally disturbed children; (b) combining educational and treatment responsibilities for more effective community programs of rehabilitation for these children and these families; (c) providing centrally located, comprehensive, professional resources of school systems and communities which are developing services to disturbed children; and (d) utilizing paraprofessional neighborhood people and parents to assist in major portions of the treatment process.

Figure 1

COORDINATED SERVICES FOR DISTURBED CHILDREN



In addition, the preschool component of the Network prototype, Rutland Center, in Athens has been selected by the Bureau of Education for the Handicapped, United States Office of Education, as an exemplary program worthy of national dissemination. This project is entitled, "Technical Assistance for Replication of the Rutland Center-Developmental Therapy Model." The new grant has made the Rutland Center Model available for replication outside of Georgia to programs which seek to develop psychoeducational services for preschool youngsters with emotional or developmental problems. Five replication sites currently under way are: Seneca, South Carolina; St. Paul, Minnesota; Middleton, Wisconsin; Plainview, New York; and Tuscaloosa, Alabama. The project objectives include: (1) to disseminate materials and information developed during the demonstration phase of Rutland Center subsequently field tested in the Georgia Psychoeducational Center Network for one year to any interested programs and agencies; (2) to provide technical assistance and program planning for each of approximately five selected programs which plan to replicate a component of the Rutland Center Developmental Therapy model; (3) to train specified staff members at each replication site.

Of the fifteen existing Psychoeducational Centers in the Network, 93 percent of them are utilizing the Developmental Therapy. Dr. Mary Margaret Wood, Associate Professor at the University of Georgia and Director of the Rutland Center in Athens, has devised a system of looking at emotionally disturbed - behaviorally disordered children. This system is called Developmental Therapy. Developmental Therapy is a psychoeducational approach to therapeutic intervention with young children who have serious emotional and behavior disorders. The approach has particular reference to children between the ages of two and eight years and is applicable to children of varying ethnic and socio-economic groups. These procedures have been used successfully also with children through age 14.

The theoretical framework for Developmental Therapy is constructed from a number of major works, theory and research, in the fields of child development, child psychopathology, developmental psychology, special education, learning theories. Results of such studies have led to the formulation of certain assumptions concerning the nature of emotional disturbance in children which have direct implication for child therapy.

Direction for developing the framework which serves as a guide for the maturational progression in developmental therapy has been provided by a number of major developmental theories. Bender, Gesell, Amatruda, Hebb, and Werner formulated significant psychobiological concepts of normal and abnormal development. The monumental programs of research conducted by Brunder, Inhelder, and Piaget on cognitive development are the foundations for the entire field of developmental psychology. These contributions have relevance for planning maturational experiences for disturbed children as well as for normal children. Similarly, psychosocial aspects of development, particularly as presented by Anthony, Erikson, and Kagen and Moss cannot be overlooked when considering a developmental approach to child treatment. The works of Krathwahl, Bloom and Masia, Turiel, and Wolff offer considerable direction in affective and moral development. From aspects of these major writings, Developmental Therapy, the therapeutic curriculum, the stages of therapy, and the developmental objectives for planning and evaluating a child's progress have been formulated and are being used.

The Developmental Therapy curriculum contains four basic curriculum areas: behavior, communication, socialization, and (pre) academics. These areas are proving adequate to encompass the varied presenting problems of the seriously disturbed school child and to provide a logical entry for the therapist and to selection and simulation of normal childhood experiences when planning the treatment program. By establishing therapeutic goals within each area and following the outlined treatment sequences, the therapist will facilitate growth of cognitive, affective, and sensory motor abilities while reducing or eliminating pathological and nonconstructive behavior. With Developmental Therapy the therapist assists the child in the assimilation of selected experiences designed to facilitate the emergence of constructive behaviors. Educational materials and techniques are used as vehicles for implementing the process.

Developmental Therapy is designed for special education and mental health workers, parents, volunteers, and para-professionals using the therapeutic classroom setting with five to eight in a group. It is a treatment process which (a) does not isolate the disturbed child from the mainstream of normal experiences; (b) uses normal changes in development as a means

to expedite the therapeutic process; (c) uses normal sequences of development to guide the therapeutic process; and (d) has an evaluation system as a part of the therapeutic process.

One may ask. "What about the cost?" Is the cost of community based treatment of seriously emotionally disturbed children too high? One alternative to the treatment offered through the community psychoeducational centers is hospitalization, a highly expensive method of dealing with the problem. Cost of hospital care in Georgia may range from $3,100 to $13,000 or more per child per year. By contrast, Network services cost less than $1,080 per child per year, about 1/3 to 1/10 the cost of institutionalization.

Community psychoeducational care, then, is a sound economic investment in the future of Georgia's most precious resources, its children. The Georgia Psychoeducational Center Network is a vital part of a total program of services for children with mental illness or severe social and behavioral maladjustment being offered in the state of Georgia today.

COMMUNITY YOUTH SERVICES

AN EFFORT TOWARD THE COMMUNITY-BASED PLACEMENT AND TREATMENT OF JUVENILE OFFENDERS

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Introduction

Special Projects were created to offer community-based programs in lieu of institutionalization for delinquent youth committed to the Department of Human Resources. The Special Projects include the Day Centers, the Community Treatment Centers, and the Group Home units. These programs are strategically located in the high commitment areas of the State. These new programs bolster substantially the alternatives of treatment for juvenile courts and the communities served.

Special Projects became a reality when the Georgia General Assembly reversed a prior plan to build a new security juvenile correctional institution. This institution was to have cost the State the sum of 2.5 million dollars in construction costs alone. The legislature approved the allocation of $250,000 for use as matching funds to obtain federal funds. Over one million dollars was raised to implement the community-based programs.

The Day Center Program

The Day Center Program utilized a community-based treatment model concept as an alternative to the institutionalization of the committed juvenile offender.

There are four (4) Day Centers operational in Georgia; three are located in the metropolitan area of Atlanta, and one is located in Savannah. These locations were determined by the large number of commitments from these areas. Fulton, DeKalb, and Chatham counties committed more than 400 juvenile offenders in 1971 or approximately 25% of the total commitments.

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The Day Center Program is designed primarily for the male offender between the ages of 12 and 15. Once the child has been committed to the Department by the Juvenile Court Judge each commitment is screened to determine acceptability for the program. The retarded, multiple serious offender, and the assaultive youngsters are screened out as possible students. Each boy accepted is usually behind his normal grade placement in school, but has normal intelligence to pursue an academically oriented program.

Additionally, the child must have a home or residence in the general vicinity of the day center. We also request that the committing judge concur with our plans to place the child in a community-based program.

Depending upon the wishes and desires of the Court, the child may have a pre-placement hearing at which time a contractual agreement will be signed between the child, parents, Court and Day Center program representative. The conditions of the contract are that the child will attend school and that the parental involvement and cooperation is requested. Should the conditions of the contract be broken by the child, he will, upon the recommendation of the Center Director, be removed from the program. Again, depending upon the Court, the child may face a re-hearing and be placed in the YDC for not adhering to the terms of the contract. If the Court does not require another dispositional hearing, the child may be sent directly to the appropriate YDC. Should a child continue to be involved in delinquent activities while a student in the Day Center program, he risks return to the Court to face new charges and possible commitment to the appropriate YDC.

The program offers a four-pronged approach to treatment; individualized education, guidance and counseling, recreational therapy, and cultural enrichment. Briefly, each child has an individualized educational program based on his individual needs. Reading is especially important-there seems to be a definite correlation between his inability to read and his involvement in delinquent activities. We utilize community volunteers as tutors to help in the academic program. The recreational program is designed to be used as a therapeutic tool. Guidance and counseling are provided as needs arise. Individual and Group Counseling are used, both with students and families. Cultural enrichment is a term we use to describe that portion of our program that attempts to enlarge the cultural horizons of the boys. Most boys are from

lower economic levels and have been culturally isolated most of their lives. We take these boys to plays, movies, concerts, and similar presentations. Museums and historical places of interest are visited. This effort we hope will help boys to feel more a part of the community and will encourage him to be proud of his community and work toward its betterment. We also plan trips for camping and hiking purposes. Many boys have never been outside the urban areas and it is a special thrill to go for a trip to the mountains or to the sea.

Each Day Center operates with a staff of seven (7):

Director
Assistant Director
(2) Academic Teachers
Recreation Leader
Typist
Community Worker

The Director and Assistant Director positions are currently filled by professionally trained educators, social workers and psychologists. The academic staff is certified to teach the behaviorally disordered child. The Recreational Leader is responsible for planning and executing a therapeutic program of recreation. The Community Worker helps to interpret our program to the community and is involved in family visitations. The overall treatment approach is one of "team effort", with all seven staff members contributing to the treatment process.

Immediately we want to see our present efforts meet with a reasonable degree of success so we can encourage the statewide development of a network of community-based treatment facilities for juvenile offenders. It would be our hope that communities could be encouraged to provide the Day Center type programs. We would also like to provide Day Center programs for the committed juvenile female offender in the future.

The Group Home Program

This program also has as its major purpose the provision of another form of alternative planning for the committed juvenile offender. Youngsters selected for this program are those who have the potential for success in community-based programs but who are unable, due to whatever circumstances, to live with parents, relatives, in foster homes, etc. Need and

potential to achieve in a community-based program are given equal consideration in the selection of group home participants. This program operates both as a "halfway in" and "halfway out" program providing twenty-four hour alternative care for youngsters in route to or from juvenile institutions.

The Group Home program allows the students accepted into the homes to be gradually reintegrated back into community life. The screening process includes a review of the child's background, need and potential. Personality inventories as well as intelligence scores are considered. Trial visits are required, but the youngsters have the option to decline to enter the program if they choose.

Once accepted into the program, the youth is expected to abide by house rules and to remain active in an academic, vocational, or job-training program. Food, shelter, and clothing are provided. Allowance is provided if the youth has no source of spending money. Aside from regular program participation, the youngsters are afforded the opportunity to participate in religious, recreational, and social and cultural activities on the community level. Supervision is provided by child care workers and counseling is done by trained social work staff. A maximum of eight youngsters are served in each home setting.

Funding has been secured to operate five such homes at the present time. Two homes for boys are located in Augusta, two for girls are located in Atlanta and one is being developed for boys in Gainesville. The maximum number of youngsters which can be served at any given time in all five of the homes is forty. Probably no more than fifty can be served during any year as the youngsters selected may remain in the homes as long as the need for such a program exists.

Over 1700 youngsters were committed to the Division during fiscal year 1972. A conservative estimate is that at least 200 of these youngsters needed programs like those offered in the group homes.

If funds were available, a minimum of ten additional group homes would be needed to meet existing needs. These could be located on a regional basis and enable the programs to meet existing needs regionally at the community level. Efforts could also be expanded to allow for further development of treatment aspects in the program. Specifically,

some youngsters who simply need short term care in a peer-oriented group environment could be accepted along with youths in need of long term substitute living plans.

Screening for acceptance into a group home is done by referring appropriate youths to the director of the group home to which acceptance is sought with a copy to the director of group homes statewide. The initial screening process looks for the following:

a) Youth who do not have a home placement within the community (youth who have been unable to be placed out of institutions, and youth who may not really respond to institutionalization);

b) Youth who are willing to cooperate with such a program and who will voluntarily accept placement in such a facility; and

c) Youth who are willing to remain involved in a viable community-based program during residence within the group home.

The staff of the group home does an in-depth evaluation if they have a vacancy for the youth; otherwise, the application is kept on file. The director of the group home makes the ultimate decision on whether or not to accept a youth after the evaluation. Each group home looks for:

a) the cooperativeness of the youth

b) designing with the youth a program to be followed

c) an actual period of observing the youth to see how he will respond in the program (trial visit).

The Community Treatment Centers

The purposes and objectives of the Community Treatment Centers are:

1) To provide community-based programs for juvenile offenders committed to the Department of Human Resources in lieu of institutionalization;

2) To reduce the number of high-risk youngsters who would require service by regular Court Service staff if not institutionalized;

3) To screen youngsters suitable for community-based care; i.e., those youth needing close supervision, but not seriously at risk in or to the community if adequately supervised;

4) To establish realistic manageable caseloads wherein planning can be individualized and supervision and counseling provided regularly; and

5) To provide the supervision required at approximately one-fourth the cost of institutionalization.

The methods used in performing these tasks are:

1) To hire competent, qualified staff;

2) To limit caseload to ten to fifteen per unit worker;

3) To provide individualized planning, frequent and careful supervision, regular counseling, appropriate referrals, and organized recreational and cultural opportunities;

4) To screen youngsters through both objective and subjective methods to determine youth needs and suitability for this type placement;

5) To provide this service in areas of the state reflecting high delinquency and commitment at conveniently located, community-based centers; and,

6) To evaluate, using as nearly objective standards as are available, the success of the program in terms of reduced rates of recidivism (incidents of repeated delinquent behavior), modification of personality or intelligence, and decrease in maladaptive behavior. Also measured will be cost of this program as compared to institutionalization and cost-benefit for long-range efforts at rehabilitation as compared to those of institutionalization.

At present, Community Treatment Centers are located in Atlanta, Columbus, Gainesville, Griffin, Newnan, Thomaston, Thomasville and Moultrie. Approximately 250 youngsters can be served by these units at any given time. Commitment rates alone in at least five other locations over the state would justify expansion of this program if funding were available. If the program could be expanded to include supervision in lieu of detention, fifteen to twenty such programs would be needed.

When a child is committed, a copy of the commitment order is forwarded to the Community Unit Supervisor in that area

for screening. All committed youths from involved counties are evaluated and screened. The criteria to be met are that the youth:

a) Must have an acceptable place to reside in the community,

b) Must not be psychotic,

c) Must not be severely retarded,

d) Must not be a multiple, serious offender.

To decide the youth's acceptability, the following is done:

a) An interview of the youth,

b) An interview of the parents,

c) An interview of the youth's probation counselor, and

d) Any other interview with appropriate community agencies of persons who may be able to provide needed information.

If the evaluation looks favorable for the youth to be placed into the Community Treatment Center, then the committing judge's concurrence is requested. If at any point during the screening process it is decided to reject a youth, notification is made to the individuals concerned so that the youth can be assigned to the appropriate Youth Development Center.

It should be noted that the in-depth screening that is done normally takes only ten (10) days once initially referred. It is preferable to have a commitment review hearing at which time the court is given an opportunity to review the plan proposed by the Community Treatment Center staff. At all times, approval from the committing court is obtained before taking a youth into a program.

The Community Treatment Center programs are geared to serving youths by using already existing community resources. The Court Service Worker in each unit will ordinarily carry a maximum caseload of ten (10) cases and each Community Worker will carry a maximum caseload between three to five (3-5) cases. This allows for an atmosphere of individualized treatment planning for each youngster served.

OUTDOOR THERAPEUTIC PROGRAM

Interrelations

The Outdoor Therapeutic Program was developed by an interagency Task Force where ideas from mental health, recreation, education, and other disciplines were combined. The program in its operation, therefore, attempts to maximize the state's resources and capabilities in dealing with disturbed children and adolescents. With referrals coming from the schools, the juvenile courts, mental health centers and hospitals, and other programs involved with troubled youth, the program cuts across traditional service boundaries within the state to provide a unique and innovative treatment program for Georgia's emotionally disturbed youth.

THE OUTDOOR THERAPEUTIC PROGRAM

Human and Natural Resources Approach in the Total Delivery System

Outdoor Therapeutic Program
Ross Cooper, Director
Cynthia Wilkes, Administrative Assistant

The Human and Natural Resources approach in the total state mental health program for children and youth in Georgia involves combining the resources and expertise of two major state agencies in the development of a treatment program for emotionally disturbed youth——the Outdoor Therapeutic Program. The Department of Human Resources includes programs for mental health, vocational rehabilitation, community services and family and children's services. Programs in the Department of Natural Resources relate to parks, recreation, conservation of resources, etc. A unique and innovative program to serve emotionally disturbed youth was developed when these two major state agencies combined resources in the Outdoor Therapeutic Program.

In this program, small groups of youth will live together in an outdoor community setting where the activities and daily living experiences are designed to be therapeutic in nature for that particular group.

The Departments of Human and Natural Resources jointly appointed a Task Force to study existing programs for emotionally disturbed youth. After some initial evaluation of these services, the Task Force recommended that a more growth-oriented program was needed for these youth——a program with focus on normal developmental tasks and activities associated with youth of this age group.

The Outdoor Therapeutic Program was developed with growth orientation as the central theme. It is designed to be an extension of and compliment to existing programs for disturbed youth——whether in special education classrooms in the public schools, in psycho-educational centers, in regional

mental health hospitals or a community mental health center, in the juvenile courts or committed to a detention center.

The basic concept of the Outdoor Therapeutic Program is to bring children and adolescents into contact with peer groups and adults in a setting where therapeutic experiences provide a means for establishing personal identity and direction. Under primitive conditions of the camping situation, youth will essentially get down to the basics of living——they will learn to identify basic human needs and then to determine how those needs can best be met within the supportive framework provided by counselors, peers, and families in this setting. The Outdoor Therapeutic Program will provide a comprehensive, growth-oriented setting which is conducive to the development of realistic and positive attitudes toward living.

Services

The Outdoor Therapeutic Program will have two major service components——a short term program and a long term program.

In the short term program, intact groups of youth aged 8 to 18, or families of youth who are enrolled in some type of mental health program, will come to the outdoor setting with their agency staff for an intensive program of therapeutic experiences in the outdoors.

Planning for the short term program would include staff training by the outdoor program staff to insure that the agency staff was knowledgeable of group dynamics and processes and able to be comfortable in the primitive outdoor setting.

A member from the outdoor therapeutic program staff would be assigned to assist the agency staff and the group to develop a program of therapeutic activities designed to meet the treatment goals and objectives for this particular group. These therapeutic activities would be determined by the group's basic needs as defined in the primitive living situation. A 1:4 ratio between staff and youth is required for each group. The outdoor therapeutic program staff member assigned to the group would also provide assistance in arranging for supplies, transportation, and other needs of the group,

and would serve as resource staff for the group when the program was implemented. This person would continue to work with the group after their outdoor experience to follow through with evaluations and recommendations for further services.

In the long term or residential component of the program, a youth from anywhere in the state could be referred by his school, the juvenile court judge, the community mental health center, or any other social service system which deals with troubled youth 8 to 18 years old.

After initial screening and evaluation, these youth would be placed in a group consisting of about eight other youth who balance the needs, strengths and limitations of each other. These youth and two counselors will live and function together as a unit——eating, sleeping, working, playing——confronting and dealing with problems daily. Each group of eight or ten will have its own camp site, and will make its own decision concerning the type of facilities needed. They may also share in the design and construction of these facilities. The group will plan its own schedules, plan and prepare meals, and generally be responsible for maintaining the living unit. These and other basic tasks in which they engage daily will provide them with a foundation for becoming productive and responsible members of society.

Treatment

The wilderness setting is ideal for working with troubled children and adolescents. Here, they will not have to deal with the barage of stimuli which we experience in the complex society of today. Instead, those fears and pressures are eliminated, and a child can focus on his immediate and basic needs. The ability to meet these needs will be a function of personal creativity and willingness to assume responsibility. Challenges experienced by the youth in the primitive outdoor setting are reality-oriented and therefore have obvious significance for the child. The primitive setting allows each child unlimited opportunities to be successful in meeting his own basic needs. This is reinforced by support from counselors and peers, and these experiences foster the development of self esteem and a positive self concept.

Because of the 24 hour contact with counselors, a consistent relationship can develop between the youth and the counselor. These counselors will provide role models as they work and play right beside the youth in every situation. They will have endless opportunities to demonstrate on-the-spot how to cope with problems and how to relate with others.

When any problem situation arises, the group interrupts its activities and works through it until a satisfactory solution is developed. In addition to these immediate problem solving sessions, there are daily scheduled group sessions to evaluate the group's progress and to set goals for the future. These group sessions——the relations, support and identification which occur within the group——foster the development of trust, sensitivity, and understanding as well as providing the youth with skills for dealing with daily living situations.

In the short term program, the agency staff will be able to observe their group in a setting entirely different from the classroom or the office. Other possibilities include the development of cooperation and cohesiveness in families through primitive outdoor living experiences; or the development of social skills in a group of withdrawn adolescents.

In the long term residential program, treatment includes not only working with the child in the program but also working with the family and community at home. Treatment goals and objectives will be jointly defined by the youth, his family and the staff. Specific activities for the families and regular visits home will allow the child to continue to participate as a family member and a member of the community while he is enrolled in the program. When a child is away from his normal educational program for an extended period of time, there will be mechanisms for informal and formal educational experiences. A close relationship will be established and maintained with the local school system as well as the school where the child was enrolled previously. Educational needs will be individually determined; some children may be able to learn spontaneously through experience and natural curiosity; others may need a more structured situation.

In summary, the Outdoor Therapeutic Program allows a youth to find out who he is——to explore capabilities, to test strengths, and to identify limitations. This can be accomplished in the uncomplicated and growth-oriented atmosphere of the group in a primitive outdoor living setting.

TEACHER TRAINING PROGRAMS

TEACHER PREPARATION IN RELATIONSHIP TO TRAINING

Teacher Training in Relationship to Providing Effective Services for Behaviorally Disordered Children

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The apparent mission of our University's program is to meet the state's needs for a quality training program for the education of children with behavior disorders. With respect to our students the goal is to develop specific teaching competencies to the point where she feels capable of functioning in a school situation effectively and relatively independently.

The question might be asked, Are there special problems in the delivery of services in Georgia that are unique to our state? An honest answer is, probably not. Georgia is not particularly different than most southeastern states with respect to services for behaviorally disturbed children. A majority of states in the region have had a rather late start in providing meaningful BD services to both rural and urban school districts. As a result many of our students will be "trail blazers" in the sense of working in school systems whose personnel have had little experience in the use of BD services. Thus a special consideration in training becomes an attempt to prepare teachers to deal effectively when placed in newly established BD programs.

Turning now to an overview of the training program itself, the course of study is designed to provide certain basic ingredients which I've tried to condense into as few categories as possible. I have chosen to handle the outline of the program in brief form so I could avoid compiling a list of 1500-2000 specific competencies, to which we all pay "lip service" as we go our merry old ways of training students.

The "basics" in BD training from my vantage point include the following aspects: (1) characteristics of children with behavior disorders, with emphasis on development of basic understanding of the major behavior disorders in children especially reviewing intervention procedures such as individual

therapy, family procedures, and residential care. Various theoretical explanations of behavior disorders are an integral part of the course; (2) Methods of teaching children with behavior disorders. This course represents an overview of the major approaches to educational intervention, ranging from the diagnostic-prescriptive behavioral models, psychoeducational approaches and therapy oriented approaches such as life-space interviewing. Specific attention is paid to the differential strategies required in self-contained and resource rooms; (3) management techniques; (4) principles of behavior modification with exceptional children; (5) psychoeducational assessment; (6) general orientation to other types of exceptional children; (7) methods and materials with special emphasis on math and reading. The focus here is placed on remediation and motivation of children who are failing to learn (sometimes referred to as "learning disabled" children); and, (8) parent counseling. In addition to the on-campus training, there is a need to provide as much exposure as possible to BD children in educational situations including public schools and residential centers. To the extent possible we try to select effective teachers as practicum supervisors. The point is that if we want to turn out good teachers we should expose them to good models during the training period. Sometimes we are in the unfortunate position of sending students to train under teachers who are less competent than the students themselves. I might add parenthetically that we try very hard not to repeat our placement errors more than once.

In the discussion above, I alluded to the necessity to help the student to develop differential skills related to either self-contained and resource teaching. It should be clear that a given teacher may be competent in a self-contained unit and relatively incompetent in a resource unit. Our training program tries to deal objectively with the problems and possibilities of each model. For example, there are many specific kinds of problems a resource teacher must deal with. First she must know how to be effective in helping a majority of the teachers that she is attempting to serve. Specifically we deal with strategies involved in winning over resistant and/or reluctant teachers in the interest of better serving BD children in the regular classroom. Secondly, we discuss how to be more effective in "contracting" with principals in terms of minimum support requirements needed for effective resource services. In addition it is necessary to prepare resource teachers to develop realistic goals for in-service training programs for teachers who may be bored, minimally motivated,

and downright hostile toward BD children. The next area involves becoming acquainted and constructively using community services outside of the school. Last but not least, resource teachers need to be prepared to help school systems to use BD educational services appropriately in order to minimize failures in programs or to eliminate mediocrity of services which may have gotten started on the "wrong foot."

A final word is in order. This related to the need to differentiate between elementary and secondary programming. The fact is that we prepare teachers for elementary positions, almost exclusively. True those who express an interest in the secondary level may take one or two counselling courses and, perhaps, a course in the psychology of adolescence; and they do their practice teaching in a secondary setting. But somehow the differentiation in training tends, in fact, to be rather minimal. This is not a problem unique to our own teacher training program, it is a problem to be found in virtually every program in the country. The writer has questioned many teacher trainers in an attempt to find model secondary BD training programs, but they tend to be few and far between and the practicum facilities quite often are restricted to residential institutions or clinics, rather than as integral components of school programs.

In this brief presentation I have attempted to provide the audience with an overview of our program——its strengths and weaknesses. In my opinion our program as well as others have gotten more sophisticated and relevant than in the past and we are now in a position to train teachers who can provide positive and substantial help to the state's BD children. But clearly, there is more work to be done.